Department of Veterans Affairs

# Prevention Notes

## From the Director's Desk

Being merely weeks on board as the new Director for the National Center for Health Promotion and Disease Prevention (NCHPDP) (we gotta' do something about this alphabet soup), I will invoke the "honeymoon clause" and withhold speaking about specific issues of preventive medicine in the VA from a position which is not maximally informed. But, I can easily tell you about who I am and talk about vision for the Center and the direction which I feel is important for the VA healthcare system and the veteran patient population.

**WHO AM I?** Everyone wants to check out how *the New Guy* stacks up, so I'll make this as interesting as possible with just my formative life events as they pertain to Medicine and Prevention, to give insight to the origins of my perspective… and for some laughs. I have just finished a career in the Army which began in DEC 1968 and ended this year. I have lived through the military as a Private in Basic Training back when soldiers had no "rights", where *"one person lights up, you ALL light up,"* on-the-spot verbal and physical abuse was commonplace, and "water conservation" meant not drinking water for as long as possible. I was a Sergeant when it was very unpopular to be in the Army, in Vietnam (especially as a volunteer), and to be a Green Beret. I left the Army, the first time, because my only choice for assignment was to be part of the core cadre forming a new "leg" unit (now the famous 75th Rangers) instead of going to another Special Forces unit – and because I couldn't get promoted. I never forget my roots and my humble obligation to the front line service member.

I went to Tulane University Medical School under an Army scholarship and deferred entry into the service for one year afterward in an attempt to finish doctoral research in Biochemistry (research went afoul – but I learned kilos about benchtop dedication). Formal medical training included a flexible Medicine internship, MPH (Harvard), and Preventive Medicine residency at Walter Reed Institute of Research. I spent a decade as a primary care physician (flight surgeon and dive doc) and deployed all over the world with Special Operations units. I have been to over 50 *different* countries. Physician assignments have been with Special Forces units, Preventive Medicine positions, or higher headquarters administrative positions (Chief of Staff, Commander, Command Surgeon) – for Army as well as Joint units.

**PREVENTION?** My hard-earned clinical experience in geographically remote, God-forsaken mud-holes around the world made me a confirmed believer in Prevention as the cornerstone of Medicine, and *Primary* Prevention as the cornerstone of Preventive Medicine. Once a patient enters into a treatment process for a disease, he/she is already playing catch-up, plus has initiated an exponentially increased factor in cost. However, even with all the supportive scientific data, the corroborative personal experience of clinicians, and the subsequent eloquent verbal validations (read "lip service") given to Preventive services, Prevention is difficult to sell. It *ain't* sexy; you don't perform technically dexterous feats and bring people dramatically back from the dead; you won't see a TV drama series on it; and if it's working, you won't notice it. The backbone of Primary Prevention has never been pills or shots, but is always based *at some level* on PERMANENT BEHAVIORAL and LIFESTYLE change – something which is so obvious, readily available, simple, cheap, and completely within each of us -- but which is probably the most difficult remedy for any human to successfully institute.

**MY MANDATE?** I come with one mandate – to make the NCHP responsive to all Primary Care needs for VA Preventive Services – to become the "411" as well as the "911" for VA Preventive Medicine issues. We will be organizing and building the Center to meet this mandate, determining high priority goals, finding "low hanging fruit" as well as tackling the BIG issues, making national and cross-agency contacts, seeking opportunities to hook into DOD/CDC/HHS/Academia (etc.), to leverage research and resources to eliminate duplication in efforts, and to devise (and revise) the most sound Preventive strategies possible.

BUT, we can only begin to move in this direction by adequately connecting with the Prevention assets in the field! We want your ideas and want your input. If we have to break sacred conservative paradigms of Medicine to make an impact, then that's where I want to go. Give me a call. That's my language.

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## Inside this issue . . .



**Fall 2001 Vol. 5 #3**

National Center For NCHP HEALTH PROMOTION AND DISEASE PREVENTION

# Editor's Notes

Greetings! This Fall issue of our newsletter returns after a brief hiatus during a period of transition for the National Center. We are pleased to be back and hope that you find this edition particularly helpful. If not, let us know. We want to assist you in all of your program efforts in prevention.

The array of articles presented here reflects the vibrant nature of health care delivery in the Veterans Health Administration, especially in the area of prevention. We welcome our new Director, Dr. Steve Yevich who introduces himself in this issue. Important information about the influenza vaccine delays for 2001-02 is reported, along with a brief Post Traumatic Stress Disorder (PTSD) mini screening tool for use in a primary care setting. The primary care practitioner is likely to see an increase in traumatized individuals, especially after the September 11 terrorist event. This instrument is part of a larger manual about screening for PTSD in primary care, available from the National Center for PTSD, White River Junction, VT.

Along these same lines, John Fotiades, MD, MPH, Director, Primary Care Morbidity Project and Depression Screening Guidelines, summarizes the role of prevention discussed in the first annual Mental Illness Research, Education andClinical Center (MIRECC) conference in June. His remarks encourage primary care practitioners to be on the alert for patients with mental health problems, and once recognized, refer them to the mental health clinic. Although the meeting focused on older veterans, the message is neither age or gender specific in the VHA. Scott Sherman, MD, MPH brings us up to date on The Quality Improvement Trial for Smoking Cessation (QUITS), now in its final year. Along with this article is a brief questionnaire which will enable you to assess the progress of your medical center in the area of smoking cessation activities. Joe Murley, MD. Deputy Chief Clinical Executive, VISN 20 provides a stimulating description of a successful prevention campaign underway with some practical advice about implementing one in your network.

We are pleased to welcome back Bryan Volpp, MD, a knowledgeable source of information, in another article on the timely topic of clinical reminders, an issue under continual discussion among VA health care providers. Dr. Volpp presents recent developments regarding JCAHO documentation requirements for patient education and the role of clinical reminders in prevention and health care delivery. New to this publication is an article on the treatment and prevention of AIDS. We are happy to involve the VA AIDS Information Center and their assistance in bringing us up to date on the issues surrounding this disease, and the wealth of resources available in the VHA from their Center. Mentioned in the article by J. Michael Howe, Director of the Information Center, is a reference to an Information Letter from the Under Secretary for Health, concerning the provision of condoms as HIV prevention. See the article for details on the Letter.

Did you know that women are more likely to visit a primary care physician than men? Read about it here in a recently released report by the Centers for Disease Control and Prevention (CDC).

As in the past, we welcome any suggestions for the improvement of our newsletter. If you would like to write an article about prevention in the VHA we would be more than happy to publish it. Of particular importance to us are descriptions of innovative programs, "best practice" models that we can feature with hopes of replication at other VA sites. If you have a program in health promotion or disease prevention, that you feel others may be interested in adapting to their medical center, let us know and we will publicize it for you.

## Editorial Board

The Center is in the process of forming an editorial board for the newsletter that will assist us in recommending topics and items of interest in prevention. If you would like to serve in this capacity, let us know as soon as possible. Periodic conference calls will be held. We will rely on you to inform us of "everything prevention" in the field that can be shared with others.

## Important Dates

The next Preventive Medicine call will be held **November 13** at **1:00 PM** EST. If you have agenda items or questions concerning the call, contact Mary Burdick at **919.416.5880 Ext. 227** or e-mail her at burdi003@mc.duke.edu. The call in number is **877.230.4050 Access Code #18987**. Anyone interested in prevention is welcome.

## Healthy Happenings

In lieu of our regular featured column which will return next quarter, reminding you of important health care anniversaries, here are a few you may already be aware of. We felt them important enough to mention nonetheless.

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| **November** | Lung Cancer Awareness Month |
| | National Epilepsy Month |
| | National Diabetes Month |
| | National Alzheimer's Awareness Month |
| ****November 17** | The Great American Smokeout |
| **December** | National Drunk and Drugged Driving Prevention Month |

Dorothy R. Gagnier

Dorothy R. Gagnier, Ph.D.
Assistant Director, Education
Newsletter Editor

# Prevention Campaign in VISN 20

In 1996, then Under Secretary for the Department of Veterans Affairs, Ken Kizer, MD, made a commitment to ensure that the Veteran's Health Administration, the medical care arm of the Veterans Administration, compared favorably with any private health care system in the country. A series of Clinical Practice Guidelines and preventive services were put into place in 1996. A great deal of effort was placed into measuring performance and adhering to these Guidelines and Preventive Services, including an extensive, national External Peer Review Process (EPRP). Each VISN has manifested strengths and weaknesses with respect to compliance with these standards.

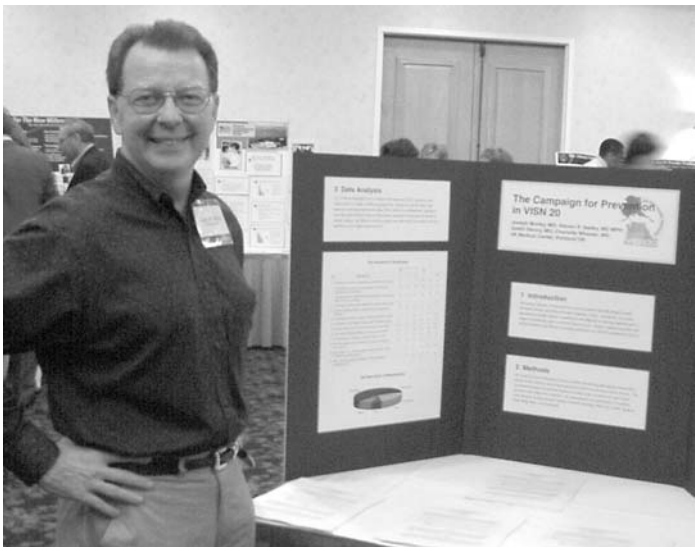
This data has been very helpful in allowing VISNs throughout the country to determine problem areas and better use their resources in providing vital services. In VISN 20 (Alaska, Washington, Idaho, and Oregon) this information led to the conclusion that while doing well, and constantly improving, there was a great deal of room for improvement in this area of services.

After initial information gathering and informal site visits, a "Campaign for Prevention" was begun, concentrating on four areas: tobacco cessation, alcohol abuse screening, obesity, and maintenance of blood pressure below 140/90. Focusing on these measures, yet examining the system as a whole, VISN 20 staff gathered information and studied the system in order to improve performance in preventive services and compliance with CPGs.

Examination of the system consisted of formal site visits, informal interviews with providers and staff, and, most importantly, implementation of a specially designed survey instrument that was distributed to all providers and other staff in the VISN. This survey consisted of 42 questions graded on a Likert scale from 1 to 5 (strongly disagree, disagree, neutral, agree, strongly agree), as well as a series of open-ended questions. 134 of 350 surveys distributed were returned (38%), with site specific return rates ranging from 27% to 50%. The results of this survey are the focus of this report.

Besides looking at VISN-wide responses, answers to all questions were examined by site, job description, time with the VA, and whether behavioral-change training had been received. Many important trends and insights into the system, its strengths and weaknesses began to emerge. It was discovered that many of the attitudes toward CPGs and preventive services were specific to certain sites or job descriptions. However, a number of VISN-wide trends emerged that may be of interest to anyone involved in providing preventive services and instituting clinical practice guidelines in the care of veterans. To understand more clearly the vast amount of data assembled, findings were distilled into ten broad trends/themes.

1. There was nearly universal acceptance of preventive services as an important part of medical care for veterans. 130 of 134 respondents agreed that preventive services are important. This conviction will be the cornerstone for moving the VISN forward in an endeavor to improve performance in this area;
2. When asked about assistance in achieving goals, numerous proposals were seen as having a potential positive impact, but specialty clinics for behavioral change and more time with patients were the ones most strongly desired. These specialty clinics were particularly important to those sites without them;
3. Blood pressure goals were important and valid, and lack of meeting goals in this practice was not due to measurement problems alone. Clearly, the providers and staff of the VISN believed that keeping the veteran's blood pressure below 140/90 was critical in promoting wellness;
4. While the link between preventive services and improved health outcomes is not in question, there are still questions concerning clinical practice guidelines being scientifically valid. More studies to determine which guidelines are seen as less valid than others, are needed;
5. There was a general lack of knowledge and comfort with behavioral change theory and implementation. Only 30 of 134 respondents have received formal behavioral change training through the VHA system;




*Dr. Murley presents findings from the prevention campaign at the recent NAVAAM meeting in August.*

6. Despite the effort expended, there was still a sense that the CPGs have not been adequately explained and/or publicized. A campaign for further awareness of the guidelines and their scientific basis is badly needed;
7. There was a sense that those providing the services have not been involved in the drafting and implementation of the clinical practice guidelines and preventive services;
8. While most agreed with the need to provide proper screening, there was a sense that perhaps screening at each visit was not warranted. This was especially true for alcohol screening;
9. There were concerns about the ability of patients to change unhealthy behaviors once they have been identified. In order to improve performance in these measures, providers need to be convinced that screening can lead to improved outcomes for their patients;
10. When queried about perceived barriers to provision of services, no clear answer other than lack of time with patients emerged VISN-wide, but individual sites showed strong opinions about particular barriers. Much of the needed changes need to occur on a site by site basis, but some important VISN-wide changes will have a broad impact.

Obviously, the gathering of this data and the initial data analysis is only the first step in VISN 20's "Campaign for Prevention." However, these finding will form the basis for moving forward in improving adherence to the clinical practice guidelines and provision of prevention services, and, more importantly, working toward improving the health of our veterans.

Clearly, an effort will have to be made to turn these findings into pertinent systemic changes. The most important finding of the study however, is that the providers and staff of the VISN, and possibly the VHA system nationwide, resoundingly believe that prevention is a critical and important part of health care for veterans. The problem is not lack of enthusiasm, but rather in systemic problems that if identified and dealt with, will allow providers of health care to take full advantage of providing the best possible care for patients.

It is also evident that a new procedure needs to be followed regarding clinical practice guidelines. The survey revealed that unlike preventive services, the attitudes towards CPGs are not as overwhelmingly enthusiastic. That's

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# Prevention Campaign in VISN 20

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not to say that providers and staff do not believe they are important and valid, but a greater effort to publicize the CPGs must be made. As part of this effort, their scientific validity needs to be reinforced. With such an effort, positive improvement in EPRP data, and, in the long term, patient health outcomes can be realized.

It is clear that the health care providers of VISN 20 believe in prevention but see numerous barriers to accomplishing it. Further, the CPGs put forth nationwide will require a renewed effort if they are to become an integral part of daily practice. This study was the first step in identifying areas that need to be affected in order to achieve better performance in the delivery of preventive services and improve compliance with Clinical Practice Guidelines in VISN 20.

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***NAVAAM Poster Session on Improving Pneumococcal Immunization Rates:*** *Madhulika Agarwal and Leticia Corpuz, Washington, DC VAMC*

# Women More Likely Than Men to Visit a Primary Care Physician

A report released July 27, 2001 by the **Centers for Disease Control and Prevention, National Center for Health Statistics**, confirms the "long-held belief" that women are more likely than men to visit a physician and are twice as likely to go for preventive care (Corwin, *Augusta Chronicle*, 7/26). The report, based on hospital surveys, finds that women made about 500 million visits to ambulatory medical care providers annually in 1997 and 1998, with the average individual woman making 4-6 visits per year (CDC, "Utilization of Ambulatory Medical Care by Women: United States, 1997-98," 7/25). An Augusta, GA-based primary care provider comments that the report's results are "not really surprising." He speculates that women are "conditioned" to go to a physician for non-emergency care, while men "won't go until their health is failing" (*Chronicle*, 7/26).

Statistics from the report, which is available at www.cdc.gov/nchs/releases/01news/newstudy.htm, are highlighted below:

- Excluding pregnancy-related visits, women visited a physician 33% more times than men (*CDC release*, 7/26).
- Women ages 15 to 44 made 50% more visits to an ambulatory care provider than did men of the same age group, while there was "virtually no difference in the rate of visits by women and men 65 years of age and over" (*CDC*, 7/25).
- Women most frequently visited physicians for a chronic condition, followed by an acute condition and then for preventive care or other non-illness purposes (*CDC*, 7/25).
- Blood pressure screening was the most common diagnostic or screening service for women, followed by pelvic exam and urinalysis.
- Private insurance was the most common form of payment for ambulatory care visits by women (50%), followed by Medicare (22%) and Medicaid (9%) (*CDC release*, 7/26/01).

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## *Mailing Announcement*

If you are currently a Preventive Medicine Program Coordinator (PMPC) at your facility, or a Prevention Network contact person, you should be receiving copies of this newsletter. If we have missed anyone, please forward your mailing information to Dorothy R. Gagnier at the National Center. E-mail address is gagni001@mc.duke.edu.

# Treatment and Prevention of AIDS in the VHA

VA is the nation's largest single provider of health care to those infected with HIV. More than 45,000 individuals with HIV infection have been treated in VA since the disease was first recognized in the United States in 1981. VA physicians were among the first to report the syndrome in 1983 when 61 patients were treated in VA's healthcare system. Today, more than 19,000 patients with HIV infection are treated at VA facilities across the nation.

HIV/AIDS patients in VA are older than the norm in the United States population, have a higher representation of minorities, and are more likely to be infected through intravenous drug use or heterosexually, than those in the general population. For example, the average age of the VA patient with HIV infection is 47 in contrast to 37 for the U.S. population as a whole; African-Americans and Hispanics represent almost 60% of the HIV infected; and, 44% acquired HIV either through heterosexual sex or intravenous drug use, as opposed to 34% outside of the system.

VA's AIDS program is a comprehensive approach with increased emphasis on outpatient services, active case management, and tracking of HIV positive veterans through a registry that provides clinical, administrative and management reports. VA care is also comprehensive, in that all licensed anti-HIV drugs on the formulary, included those approved this year by the Food and Drug Administration, VIDEX EC, Kaletra, and Trizivir. VA clinicians are international leaders in HIV care. Each clinical site has an assigned HIV coordinator, and each health care facility has extensive experience in co-morbidities, including substance use, mental illness, and homelessness, that are often typical of the VA HIV infected patient.

VA recommends that health care providers follow the *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents* (http://www.hivatis.org) that were developed by the Panel on Clinical Practices for the Treatment of HIV Infection, a joint effort of the Department of Health and Human Services and the Henry J. Kaiser Family Foundation. Included on the panel from the AIDS Program, VA Headquarters, are Lawrence Deyton, MD, MSPH, Chief Consultant for Public Health, Director, AIDS Program, and, Director, Hepatitis C Program and Sophia Chang, MD, Director, VA Center for Quality Management in HIV Care.

These Guidelines recommend considering the initiation of antiretroviral therapy when an asymptomatic HIV-infected person's CD4+ T-cell count falls below 350 cells per cubic millimeter ($mm^3$); previous Guidelines recommended consideration of therapy for asymptomatic patients with a CD4+ T-cell count lower than 500 cells/$mm^3$. Another important addition to the Guidelines is an updated section on the expanding scope of antiretroviral drug toxicities.

For asymptomatic HIV-infected patients with CD4+ T-cell counts higher than 350 cells/$mm^3$, treatment should be considered when the level of HIV in plasma is high [more than 30,000 copies per milliliter (ml) when using the branched DNA test, or more than 55,000 copies/ml when using the RT-PCR test]; previous Guidelines recommended consideration of therapy at lower levels of plasma HIV (10,000 copies/ml measured by branched DNA, or 20,000 copies/ml measured by RT-PCR). The Guidelines continue to recommend antiretroviral therapy for all patients with the acute HIV syndrome, those within six months of HIV seroconversion, and all patients with symptoms ascribed to HIV infection.

The Guidelines also include new drug-specific recommendations. Two new entries are included in the "strongly recommended" category of anti-HIV drug treatments. One of these is the recently approved protease inhibitor Kaletra, which is a co-formulation of ritonavir (approved in 1996) and lopinavir. The other new entry is the combination of ritonavir and indinavir (another protease inhibitor approved in 1996). These treatment options take advantage of the ability of ritonavir to boost the levels of other protease inhibitors, creating a potent anti-HIV combination. The protease inhibitor combinations are used along with combinations of certain nucleoside analogue reverse transcriptase inhibitors, which represent the "backbone" of anti-HIV treatments.

*The AIDS Information Center was established in 1989 as an integral part of VA's national program to disseminate information about HIV/AIDS to field staff. The Center is now a part of the VHA Public Health Strategic Health Care Group located in VA Central Office. Primarily email systems and the Web provides communications from the Center. Approximately 2000 individuals throughout the VA health care system receive HIV-related information by email. If you would like to add your name to this mailing, list, contact J. Michael Howe, MSLS.*

*The Undersecretary for Health has issued an Information Letter (August 16, 2001) detailing "Access to Condoms as HIV Prevention" in the VHA. The document provides information on the use of condoms in the prevention of human immunodeficiency virus (HIV); provides guidance and further information on the Veterans Health Administration (VHA) existing policy on providing male and female condoms through the National Formulary; and provides recommendations on the prescribing of condoms.*

*Education about risk reduction and access to condoms for male and female veterans is a key component of VHA's program to prevent HIV, hepatitis C and sexually transmitted diseases (STDs) and their impact on veterans and VHA. As the nation's largest single provider of HIV care, it is important that the Department of Veterans Affairs (VA) be a leader in the integration of HIV prevention into clinical care.*

*Contact the Publications Officer at your facility for more information about this letter, or download it from the web by visiting the Aids Center web site listed below, bottom of p.6.*

The goals of therapy according to the guidelines are maximal and durable suppression of viral load; restoration and/or preservation of immunologic function; improvement of quality of life; and, reduction of HIV-related morbidity and mortality. The tools to achieve the goals of therapy are: maximize adherence to the antiretroviral regimen; rational sequencing of drugs; preservation of future treatment options; and, use of resistance testing in selected clinical settings.

Providing the necessary care to a veteran with HIV/AIDS, however, is complicated by several factors. HIV disease is a complex, chronic disease that requires frequent (every three months) clinic visits and laboratory tests. Patients must take multiple medications that often include antiretroviral drugs (three or more), antibiotics to prevent infections, drugs to manage the side effects of antiretrovirals, and drugs to treat other illnesses such as, for example, hypertension. Multiple toxicities to highly active antiretroviral therapy is a particularly, difficult problem that requires constant attention. Short-term symptoms include nausea/ vomiting, rash, kidney stones, weight loss, diarrhea, and headache. Long term symptoms include fat redistribution, metabolic disorders, hyperglycemia/diabetes, and lipid abnormalities. Co-morbid conditions also complicate the care of the veteran with HIV disease.

In addition to the treatment and prevention of HIV infection, VA conducts wide-ranging research on HIV related topics, from basic studies of the mechanisms of HIV to clinical trials and assessments of the costs for patient care. Special research initiatives are a critical part of VA's response to AIDS. AIDS research is an integral part of VA's efforts to improve the diagnosis, treatment, and prevention of HIV infection. Current system-wide HIV research projects include participation in the international OPTIMA Study, which examines treatment strategies in patients who have failed available drug regimens, and creation of a large, observational cohort to assess the course of HIV in an aging population.

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# Smoking Cessation: Lessons Learned from a Multi-Site Organizational Trail

*In 1998, Scott Sherman, MD, MPH, wrote an article for our newsletter outlining a VHA study, whose purpose was to evaluate methods for guideline implementation regarding smoking cessation. The study asks whether or not evidence-based quality improvement is helping institutions become more successful at getting patients to quit smoking. The following article relates recent findings from this investigation.*

We are now in the fourth and final year of the Quality Improvement Trial for Smoking Cessation, more familiarly known as QUITS. This study is a randomized trial using evidence-based quality improvement, to implement national guidelines for smoking cessation. In practical terms, that means project staff help each of the intervention sites improve the quality of smoking cessation care throughout each institution. Agency for Healthcare Research and Quality 2000 Guidelines for tobacco use control were used in the investigation. Each of the sites worked hard to set institutional priorities for smoking cessation, develop a plan to meet those priorities, and implement the plan. The "evidence-based" part of it is that the QUITS project staff helped each site select interventions that the research literature suggests would be effective and avoid ones that would likely be ineffective. One might ask what has been learned from the first three years of the investigation. Based on semi-structured interviews with a national sample of smoking experts, site visits to each of the intervention sites, and countless conversations, the following lessons are suggested.

*(1) Hard work, NOT hardly working.* Almost all of the 20 initial sites in the study, as well as the 20 sites in Dr. Anne Joseph's (Staff Physician, VAMC, Minneapolis) ongoing VHA study (Guideline Implementation for Tobacco), have a smoking cessation clinic with access to smoking cessation medications at minimal cost. Very dedicated individuals, who really care a lot about helping people to quit smoking, run nearly all of these smoking cessation programs. Many of these smoking clinic coordinators put in a tremendous amount of extra effort, in spite of numerous other competing responsibilities.

*(2) The more things change, the more they stay the same.* The smoking cessation programs at the ten intervention sites in QUITS all had distinctly different designs, features, numbers of visits, and other characteristics. Yet it was remarkable that all of them had similar success rates. While there is obviously a lot of variability depending on how and when measurements were made, the typical program had a short-term success rate of 30-50% and a long-term success rate of 10-25%.

*(3) One man's ceiling is another man's floor*. Current EPRP measures are not helpful in improving the quality of care regarding smoking cessation at individual sites. If you look at the rates for asking patients about smoking and advising smokers to quit, you notice that nearly all the sites are "at the ceiling," with rates of 95% or higher. This is both good and bad. The good part is that we all essentially get A's for asking about smoking and advising smokers to quit, something that was hardly happening at all five years ago. On the other hand, each site still has a smoking prevalence of 20-30%, meaning that we have a lot of work still to do. Unfortunately, sites cannot use the EPRP results to help them plan what to change, since they show near-perfect performance everywhere.

Given all of the above, the natural question is what should we do next? Here are some additional lessons and thoughts:

*(4) Look at the forest, not the trees.* A consensus conference summary I read several years ago suggested that we should not be focusing on how to improve the success rate of our smoking cessation programs, but rather on how to get more people to use them. Our data above would support this, as there were few differences between programs. This suggests that it would take a lot of work to make a dent in the success rate and even then it might not occur. Instead, the primary goal of any institution's smoking cessation efforts should be on how to get more people to make quit attempts, either on their own or through the smoking cessation program. At a typical medical center with 20,000 patients, you can estimate that 5000-6000 patients smoke and perhaps 2500-3000 are interested in quitting. As smoking cessation coordinator, or preventive medicine program representative, you need to think about how you are either going to get more of these people to the smoking cessation program or get more of them to quit outside of the smoking cessation clinic. Remember if they don't try to quit, they won't become non-smokers.

*(5) Don't put all your eggs in one basket.* The best approach is to intervene at multiple levels – the patient, the provider, the clinic, and the entire site. Thus a typical effective plan might include flyers for patients, incentives for providers, and assistance in referring patients, three strategies with very different "mechanisms of action."

*(6) Go where the money is.* If all the research articles on smoking cessation were stacked up, the tower might reach to the Moon. The number of articles is daunting. However, the vast majority are either about different medications for smoking cessation or about the health effects of smoking. There are relatively few on organizational approaches to smoking cessation. Therefore, don't waste your resources on unproven or ineffective approaches. Go with what works. Finding those interventions can be challenging at times, but the national guidelines are a nice place to start. Our study discovered this to be so.

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# Treatment and Prevention of AIDS in the VHA

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In summary, HIV is a chronic disease and, with treatment, survival is long-term. Patients who are treated with antiretroviral medications experience profound drug toxicities. The management of patients with HIV demands specialized knowledge of HIV disease, of drug interactions and effects, and of non-HIV related illnesses that occur as a normal consequence of aging. Approaches to the treatment of HIV disease change rapidly, and it is essential that VA health care providers respond quickly as new drugs are developed and approved, new diagnostics become available, and management strategies change. By doing so, it will be possible for VA to provide the highest quality of care available to the veteran population.

For more information about HIV/AIDS, see the AIDS Information Center web sites: Intranet: http://vhacoweb1.cio.med.va.gov/aidsinfo; Internet: http://vhaaidsinfo.cio.med.va.gov/aidsctr and the AIDS Program web sites: Intranet: http://vhacoweb1.cio.med.va.gov/aidsservice; Internet: http://vhaaidsinfo.cio.med.va.gov/aidsservice.

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# How is Your VA Facility Doing at Helping Patients Quit Smoking?

Helping smokers to quit effectively is best considered using a *systems* approach. This requires consdering not just the individual provider-patient relationship, but also what is happening at the clinic level, the facility level, and the organization level. Use the following checklist to review what your facility is currently doing, and to help you consdier where future efforts might be directed.

| | | | |
|---|---|---|---|
| **I.** | **Identifying Smokers** | **30 Points Total** | **Your Score** |
| 1. | Is there a *system* in place (e.g., part of vital signs) to ask about smoking at *every visit* in *every clinic*? | 15 points total (10 for primary care, 5 for all other clinics) | |
| 2. | Do the people assessing smoking status rountinely refer smokers for further treatment? | 4 points | |
| 3. | Are there reminders (e.g., Post-its) for providers when a smoker is identified? | 4 points | |
| 4. | Is performance of the screening system monitored on a regular basis? | 2 points | |
| 5. | Is data on smoking status stored in a database where it can be accessed later? | 5 points | |
| **II.** | **Provider Intervention** | **15 Points Total** | |
| 6. | Are providers trained about smoking cessation on a regular basis? | 3 points | |
| 7. | Are smoking cessation resources (e.g., kits, brochures) available in every exam room? | 4 points | |
| 8. | Is institutional performance at smoking cessation measured? | 3 points | |
| 9. | Are providers given feedback about their *individual* performance at smoking cessation on a regular basis? | 5 points | |
| **III.** | **Staff Dedicated to Smoking Cessation** | **15 Points Total** | |
| 10. | Is someone identified as the tobacco dependence coordinator for your facility? | 4 points | |
| 11. | Are the respnosibilities of the tobacco dependence coordinator clearly defined? | 4 points | |
| 12. | Is the performance of the tobacco dependence coordinator measured on a regular basis? | 4 points | |
| 13. | Are the roles of each discipline (e.g., RN) defined with respect to smoking cessation? | 3 points | |
| **IV.** | **Hospital Policies Related to Smoking Cessation** | **15 Points Total** | |
| 14. | Is there a system in place to identify smokers on admission to the hospital? | 4 points | |
| 15. | Is there a clinician identified to provide smoking cessation counseling to all smokers after admission to the hospital? | 3 points | |
| 16. | Are all hospitalized patients who use tobacco offered tobacco dependence treatment? | 3 points | |
| 17. | Are pharmacological treatments for smoking cessation available to inpatients? | 3 points | |
| 18. | Are hospital staff educated regularly about smoking cessation? | 2 points | |
| **V.** | **Services Offered for Smoking Cessation** | **15 Points Total** | |
| 19. | Is there a smoking cessation clinic at your facility? | 5 points | |
| 20. | Is the waiting time for a smoking cessation clinic appointment 1 month or less? | 3 points | |
| 21. | Are smoking cessation medications routinely used by the smoking cessation clinic? | 4 points | |
| 22. | Can primary care providers prescribe smoking cessation medications? | 3 points | |
| **VI.** | **Performance Incentives for Smoking Cessation** | **10 Points Total** | |
| 23. | Are there incentives for primary care providers with respect to smoking cessation? | 5 points | |
| 24. | Are there incentives for other staff with respect to smoking cessation? | 5 points | |
| | A perfect score would be 100 points. Add up your score to get your total. | **TOTAL POINTS:** | |

Designed by Scott Sherman, MD, MPH — Adapted from the 2000 PHS *Training Tobacco Use and Dependence* guidelines

# Impact of Mental Health on Illness in the Primary Care Setting: A National Program on the Older Veteran

In June, 2001, providers from Primary Care, Mental Health and Geriatrics convened in New York City to participate in a national VHA conference on topics of importance to all three disciplines. The topics exemplified the principles of secondary prevention, namely recognizing mental health disorders in Primary Care and Geriatrics before complications arise. Issues discussed at the meeting related to the recognition of Depressive Disorders, Post Traumatic Stress Disorder, Substance Abuse, Dementia and Delirium. A cadre of recognized faculty presented current information in these subject areas.

The underlying message emphasized in the majority of talks focused on the fact that many patients with a variety of clinical or sub-clinical mental health problems are not likely to ever walk through the doors of a mental health clinic. Most of these patients will present with physical complaints and be seen by a primary care provider. Primary care providers need to have a high index of suspicion for a mental health component to their patients' physical complaints, especially when a thorough work-up fails to identify any medical cause. Furthermore, recognizing and managing such mental health disorders can potentially decrease complications from the disorders in the future and contribute to the delivery of quality and comprehensive care.

Two veterans delivered the keynote address for the conference, further emphasizing the importance of screening for mental health disorders in primary care when meeting the health care needs of veterans. Mr. Rusty Bales and Mr. David Grooner, are both World War II veterans who served in the US Air Force. They summarized their heroic experiences of survival after being shot down over the jungles of Burma. The two American heroes emphasized the trauma they experienced while spending 22 days in Burma with minimal supplies and the constant fear of being captured by the enemy. David Grooner related the following: "I had read in a Reader's Digest article, just prior to having our plane shot down, that the enemy often communicated with each other using bird calls. After I ejected from the plane, my parachute landed on a tree bank, where I was stuck for two days. During that time I heard a variety of birdcalls, and remembering the Reader's Digest article, I was terrified. I knew the enemy we were dealing with took no prisoners, and that if we were captured, we would have been beheaded".

Although Mr. Bales and Mr. Grooner recovered well from the trauma they experienced, they reminded us that not all veterans have done as well. While Post Traumatic Stress Disorder (PTSD) has originally been associated with veterans of the Vietnam era, it is important to appreciate the fact that this disorder is not unique to this age cohort. VA's efforts to provide clinical services for veterans suffering from PTSD originated with the establishment of the Vet Center program in 1979. Although the initial legislation, Public Law 96-22, restricted eligibility of these services only to Vietnam Veterans, current law has extended eligibility to any veteran who served in the military in a theater of combat operations during any period of war, armed conflict and/or peace keeping missions. Since the Vet Centers have initiated services to veterans of other than the Vietnam era, they have provided outreach care to over 39,000 Korean and World War II veterans.

Mr. Bales and Mr. Grooner emphasized the fact that many World War II veterans suffer from their traumatic combat experience in silence because no one ever asks them about it. These symptoms may only manifest several years latter, possibly precipitated by Hollywood movies such as "Pearl Harbor" or "Saving Private Ryan". They advised the participants to ask their patients about their combat experience and the potential impact it may have had on their lives, in an attempt to not only screen for PTSD, but other mental health conditions, such as depression and substance abuse.

The conference presented other topics related to prevention issues as well. These included:

- Educating patients and family members on mental health issues;

*Left to Right: Dr. John Fotiades, Mrs. Rusty Bales, Mr. Rusty Bales, Mr. David Grooner, Mrs. David Grooner*

- How to recognize depression in primary care settings and get the patient to accept the diagnosis;
- What every primary care provider needs to know about PTSD and the older veteran;
- Providing smoking cessation techniques for your patients;
- Recognizing and treating the causes of agitation in the elderly;
- Drinking limits in the elderly: When does 'enough' become 'too much?';
- Distinguishing the 4Ds: Symptoms related to depression, drugs, dementia or delirium;
- Recognizing the etiology of Sub-Syndromal symptoms;
- Motivating patients to abandon unhealthy choices;
- Keeping our patients safe: Recognizing delirium before it's too late;
- Keeping our patients safe: Recognition and intervention in suicide.

Each of the meeting presentations will be available on videotape through the VISN 3 Mental Illness Research, Education and Clinical Center (MIRECC). Anyone interested in obtaining any of the videotapes may contact Mr. Mark Levinson at 718.584.9000 Ext. 3698.

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# Reminders Become Documentation Tools
# Clinical Reminders in CPRS

*This is one in a continuing series of articles on clinical reminders, submitted by Dr. Volpp. Bryan has been a frequent presenter at VHA conferences, most recently at the annual prevention meeting in Anaheim last year and the NAVAAM meeting in August, 2001. Remarks related to JCAHO documentation requirements for patient education and the role of clinical reminders, presented at the NAVAAM meeting, are included in this report.*

Version 1.5 of the Clinical Reminders software was released to the field in June 2000.

This version of Clinical Reminders has overcome some of the limitations of the prior version.

1. Medications (drugs or drug classes) can be used to trigger or satisfy reminder;
2. Items that are ordered can be taken into account when running the reminders;
3. Some types of data (labs, xrays, education topics, exams, immunizations) that have been used to satisfy a reminder can now be used to also trigger a reminder;
4. Mental Health tests can be used in reminders;
5. Combinations or findings can easily be used to trigger or satisfy reminders (e.g. reminder satisfied if a an education topic and a lab test are done);
6. Reminders can be easily triggered or satisfied by a value of a lab test or vital sign;
7. Outside results from other VA facilities or outside physician offices can be easily recorded;
8. Reminders can be grouped by disease or by responsible discipline (e.g. Nursing Reminders).

In addition, the clinical reminders have become interactive tools for documentation. The reminders may now have reminder dialogs associated with them to allow the user to enter documentation, data and orders while processing a reminder.

From the individual reminder on the notes tab of the chart, you can 1) display information on why the reminder is due, applicable or resolved; 2) launch to web links related to the reminder or the disease; or 3) or use a dialog to process and act on the reminder. For example, a pneumococcal vaccine reminder might be due on a patient. The reminder could reference the CDC website on pneumococcal vaccination for the most recent guidelines on adult immunizations. When you click on the reminder, a dialog similar to **Figure 1** might appear.

From this dialog, you can 1) order the vaccine; 2) record administration of the vaccine 3) enter an outside or historical vaccination; and/or 4) record refusals or contraindications. Clicking any of these check boxes will add the text to your progress note and enter whatever data needs to be entered in the background (orders or PCE data). Clicking the 'NEXT' button will take you to the next reminder.

A reminder resolution dialog could be set up to include all of the pertinent labs and exams for a particular disease. For example, a reminder resolution dialog for a hemoglobin A1c for diabetic patients might also include prior results, the ability to enter outside results, and the ability to order other tests related to the patient's diagnosis (see **Figure 2**).

*continued on page 10*

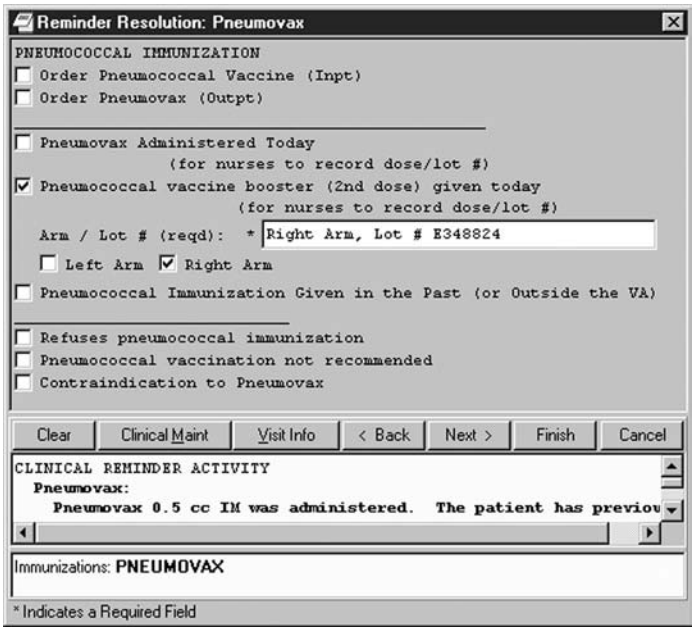


**Figure 1**

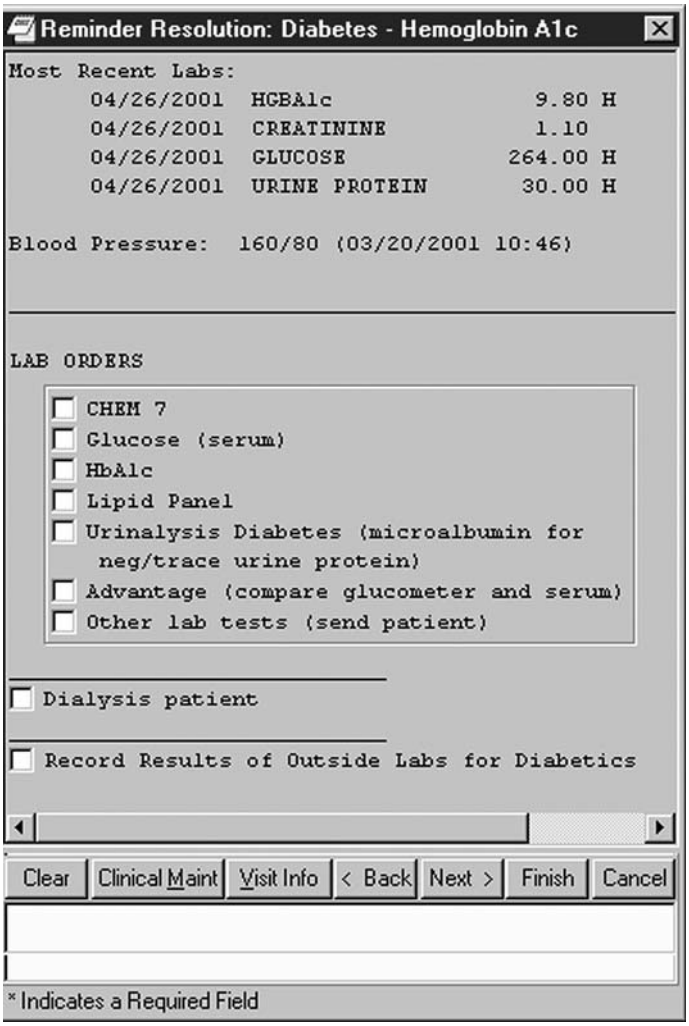


**Figure 2**

# Influenza Vaccine Delays 2001-02

Plan now for the coming flu season. Develop plans to target vaccine first to persons at increased risk of influenza complications and to health care workers in the event of serious delays or shortage. "The flu shot is the best protection you can give your patients against influenza and the complications of this disease", states the Centers for Disease Control (CDC). Although delays in availability of influenza vaccine supplies are expected for the 2001-02 flu season in comparison to last year, the national outlook is brighter and a greater total flu vaccine supply than in the last season, is projected by the CDC. The VA expects to receive flu vaccine as contracted: 25% by 9/17/01, 40% by 10/15/01, and the remaining 35% by 11/30/01 (similar to actual delivery last year).

The Advisory Committee on Immunization Practices (ACIP) recommends that providers should continue vaccinating patients through December and later, as long as vaccine is available. The target groups are people at high risk of complications, people 50 to 64 years old, and those who can transmit to those at high risk. High risk groups include people age 65 and older, residents of nursing homes and other long term care facilities, people with serious chronic disorders, and women who will be in the second or third trimester of pregnancy during the influenza season. According to the ACIP, "People develop peak levels of protective antibody against influenza approximately 2 weeks after vaccination. In the US, peak influenza activity can occur any time during December through March. During the past 19 influenza seasons, peak activity occurred in December (21%), January (26%, February (37%) and March (16%)."

For more information, go to the CDC web site at:
http://www.cdc.gov/nip/flu, www.cdc/gov/nip/flu/Best_Practices.htm; http://www.cdc.gov/mmwr/cme/conted.html

CME, CEU, and CNE continuing education units are available.

## Td Vaccine Shortage

Tetanus-Diphtheria (Td) vaccine is in short supply. To assure vaccine availability for priority indications, CDC recommends that "all routine Td boosters in adolescents and adults should be delayed until 2002." CDC also recommends "recording the names of patients whose booster is delayed during this shortage so that when Td supplies are restored, these patients can be notified to return to their health-care provider for vaccination." There have been 30 to 45 tetanus cases per year reported nationwide over the past decade and no increase reported during the current shortage.

For more information, go to the CDC web site at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5020a8.htm, and http://www.cdc.gov/nip/vaccine/tetanus/tet-faqs-provider.htm.

Mary B. Burdick, PhD, RN
Assistant Director, Field Liaison

# Reminders Become Documentation Tools Clinical Reminders in CPRS

*continued from page 9*

### Patient Education

The dialogs can be configured to collect patient education topics and information on barriers to education, readiness to learn and preferences for learning as well as the level of understanding and the methods used to determine understanding. Since this information is collected in a reminder dialog, it will show in the progress note and also can be shown in a health summary. Many sites have set up a health summary on the reports tab of CPRS to display all education topics and information on barriers, readiness, learning preferences in one single index. Sites that have used this method to meet Joint Commission standards, have reported that it was well-received by the surveyors.

Since reminder dialogs can be used as templates (new feature with version 15 of CPRS – released June, 2001), this template can be available for users at any time to record patient education. And with version 16 of CPRS (released early September, 2001), the reminder dialogs can also be attached to specific note titles and to consult reason for requests. This allows for text creation and data capture in those specific contexts. For example, a note title of "PATIENT EDUCATION" might have a dialog associated with it that includes multiple education topics, barriers, etc., as well as the option to refer the patient to Social Work, Dietetics or Nursing for more detailed educational interventions.

The VISTA Clinical Reminders package can be used to facilitate documentation and provide simple tools to record historical information that can then be used to make the reminders more accurate. When configured within CPRS, Clinical Reminders provide interactive tools with links to patient education materials, guidelines, and up-to-date resource information for providers. When a reminder is due, the provider can act on it, create documentation, orders and have the encounter data entry done in the background. This process ensures that the documentation, the orders and the encounter data are in synch.

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# Screening for Post Traumatic Stress Disorder (PTSD) in a Primary Care Setting

The primary care practitioner is likely to see an increase in traumatized individuals after a disaster or September's national terrorist event. Many of these patients will present with physical rather than mental/emotional symptoms. It is recommended that primary care providers educate themselves about the effects of trauma on individuals, and routinely screen for trauma in their clinics after major disasters.

## The Use of a Primary Care Screen

The accompanying table shows the Primary Care PTSD Screen (PC-PTSD) that has been designed for use in primary care and other medical settings. The PC-PTSD is brief and problem-focused. The screen does not include a list of potentially traumatic events. There are two reasons for this:

- Studies on trauma and health in both male and female patients suggest that the active mechanism linking trauma and physical health is the diagnosis of PTSD. In other words, the relationship between trauma and health appears to be mediated through a current PTSD diagnosis.
- A symptom-driven screen, rather than a trauma-focused screen, is attractive to primary care staff who may not be able to address a patient's entire trauma history during their visit with the patient. Such a trauma inquiry might be especially problematic with a VA population where the average number of traumatic events meeting criterion A* for PTSD is over 4.

A positive response to the screen does not necessarily indicate that a patient has post-traumatic stress disorder, but it does indicate that a patient may have PTSD or trauma-related problems and that further investigation of trauma symptoms by a mental health professional may be warranted.

## Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…

| | | | |
|---|---|---|---|
| 1. | Have had nightmares about it or thought about it when you did not want to? | YES | NO |
| 2. | Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? | YES | NO |
| 3. | Were constantly on guard, watchful, or easily startled? | YES | NO |
| 4. | Felt numb or detached from others, activities, or your surroundings? | YES | NO |

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any two items or the single hyper-arousal item (Item #3).

*Criterion A specifies that a person has been exposed to a catastrophic event involving actual or threatened death or injury, or a threat to the physical integrity of him/herself or others. During this traumatic exposure, the survivor's subjective response was marked by intense fear, helplessness, or horror.

**Education Materials:** Patients who screen positive for PTSD (and their families) may also benefit from educational materials about trauma and PTSD, such as those found in the National Center for PTSD web site Fact Sheets Section.

*Persons interested in receiving a copy of a manual dealing with this topic, or for more information on PTSD, may contact:*

Patricia A. Watson, Ph.D.
Deputy for Education and Clinical Networking, National Center for PTSD
802.295.9363 Ext. 6071 or visit the PTSD Web page at www.ncptsd.org

# San Diego NAVAAM 2001 Meeting Photos

*(Clockwise from left)Lois Katz, Rose Mary Pries, other participant. Bottom Row: Mark Stanton, Kathy Zeiler (NAVAAM President), Dr. Thomas Garthwaite, Linda Ferry*


# Anthrax, Anthrax, Anthrax…Having the GUTS to make the call

The medical perspective on bioagents has changed in the past month. The amount of information (and mis-information) about anthrax is overwhelming. A whole host of "experts" has emerged. *BUT DON'T WORRY*…The number of clinicians who have actually had a case of anthrax walk in from the street, undiagnosed, is probably a two-finger count. Furthermore, the body of knowledge about anthrax from which we are working today, will change within six months. So, *DON'T WORRY*...nothing is engraved in stone about anthrax as a disease. Don't feel behind the power curve.

Depending on the route of infection, signs and symptoms can include nausea, vomiting, diarrhea, fever, malaise, fatigue, itching, boils and "the black scab" (guess how many people have actually seen a black scab??), chest pain, difficulty breathing, many other respiratory symptoms, and "don't feel well." How many other diseases do you think have the same presentation? Lots!

Notwithstanding the recent concentration by the media on anthrax, remember that any organism/toxin can be used in biowarfare – it's just that anthrax can be disseminated and is rapidly fatal if untreated. A bioagent can be as simple as fecal material intentionally on gloves of a food handler at a cafeteria – or in the rinse tub for beer mugs at a bar – or how about someone with the "flu" or pulmonary tuberculosis intentionally coughing in a confined space such as an airplane or elevator.

*DON'T WORRY*… The EXACT biological agent, strain, and antibiotic sensitivities are NOT IMMEDIATELY important. No one is expecting that little-old-you, sitting with a load of 40 patients, will have the luxury of devoting all your mental powers to nailing the diagnosis. JUST IDENTIFYING A POSSIBLE BIOLOGICAL ATTACK can be very hard to do when you're out there all alone, seeing the usual daily onslaught of aches and sprains and rashes and diarrheas and flu-like syndromes. JUST HAVE HEIGHTENED CLINICAL SUSPICION!!!!!

SUSPICIOUS? ACT NOW!!! In the case of anthrax, you must treat immediately – if not treated before symptoms begin, it is likely to be fatal. Your job is to have a suspicion – a clinical sense that you might be dealing with something extraordinary. This might just be a gut feeling. If you are working alone, begin an appropriate antibiotic, alert an authority like the CDC at 770.488.7100; if necessary, call 911 to make the contacts for you!! Do not be afraid to activate the contingent of "experts" to do the detective work.

*DON'T WORRY*… about "crying wolf"! You will look much more foolish if you miss a case. When fingers start pointing, and everything is examined through the "retrospect-oscope," even the WTC incident looks like it could have been completely avoided. However, PLEASE, don't entertain frivolous suspicions.

Which brings me to the next related topic: anxiety, stress, heightened tension, over-sensitized suspicion, and mass hysteria associated with the threat of bioterrorism. These reactions will only increase in the next months as the nation realizes the potential for mass disease. They can manifest as clinical disease or present as imagined symptoms – so keep that in the back of your mind. Calm your patients. Don't blow off complaints because of "stress." Err on the side of prudence.

**Yevich's Rule of Thumb:** Don't do or prescribe anything for your patients which you wouldn't do for your own family; don't fail to do or prescribe anything for your patients which you WOULD do for your own family!!!

What to tell your patients? Here's some basic stuff for FAQ.

1. First of all, read up on anthrax (e.g. the Army's NBC website at http://www.nbc-med.org has current and reliable information.)
2. Anthrax is introduced through scratches or abrasions of the skin, wounds, inhalation of spores, or ingested through contaminated food/water. It is NOT passed from patient to patient.
3. *Antibiotics as prophylaxis?* Scientific fact is that inappropriate use of antibiotics can lead to development of resistance, and then the antibiotic will be useless when it is really needed. Use good judgement.
4. *Gas Masks?* These are presently viewed as being impractical. There won't be a warning that a biological attack will take place, so one would have to wear the mask 24/7; remember that filters in masks constantly need changing; where combined chemical/biological agents are used, full, impermeable, protective clothing is also required.
5. Use the usual simple precautions of Preventive Medicine: eat only properly cooked and served food; use safe water; avoid questionable food and water sources; wash hands with soap and water; don't handle bodily fluids without universal precautions. Special isolation precautions for infected anthrax patients are not required.
6. *Vaccine?* Anthrax vaccine availability is very limited. In addition, our present anthrax vaccine may not be effective against an "engineered" anthrax organism. Maximal protection requires a full series (6 shots) with annual boosters; three doses may be sufficient to provide fairly good protection. But remember that any vaccine protection can be overwhelmed by a sufficiently high dose of a bioagent. The shots should not be used frivolously – there is a mild-to-moderate, and rarely severe, reactogenicity.

Questions or problems? *DON'T WORRY*...Call me at 919.416.5880 Ext 224.

– yevich

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Veterans Affairs Medical Center
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Durham, NC 27705
*Address Correction Requested*

Putting Prevention Into Practice in the VA